2005 Quality Assurance Reporting Requirements Specifications Manual
(2005 QARR/ HEDIS® 2006 /CAHPS 3.0H®)

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Table 1: 2005 QARR/HEDIS 2006 - Table of Required Measures					
Payer	**Commercial**	**Medicaid**	**Child Health Plus**	**Specifications**	**Additional Comments**
Measure			**Effectiveness of Care**		
Childhood Immunization	✓	✓	✓	HEDIS 2006	Medicaid Member-Level File Required.
Lead Testing	✓	✓	✓	NYS-Specific	Medicaid Member-Level File Required.
Appropriate Treatment for Children with Upper Respiratory Infection	✓	✓	✓	HEDIS 2006	Medicaid Provider File Required.
Appropriate Testing for Children with Pharyngitis	✓	✓	✓	HEDIS 2006	Medicaid Provider File Required.
Colorectal Cancer Screening	✓	NR	NR	HEDIS 2006	
Breast Cancer Screening	✓	✓	NR	HEDIS 2006	Administrative Only per HEDIS.
Cervical Cancer Screening	NR	NR	NR	HEDIS 2006	Rotated for 2005 reporting per HEDIS.
Chlamydia Screening in Women	✓	NR	NR	HEDIS 2006	
Controlling High Blood Pressure	NR	NR	NR	HEDIS 2006	Rotated for 2005 reporting per HEDIS.
Beta Blocker Treatment after Heart Attack	✓	NR	NR	HEDIS 2006	
Persistence of Beta-Blocker Treatment	✓	NR	NR	HEDIS 2006	
Cholesterol Management for Patients with Cardiovascular Conditions	✓	✓	NR	HEDIS 2006	Medicaid Member-Level File Required.
Comprehensive Diabetes Care	NR	NR	NR	HEDIS 2006	Rotated for 2005 reporting per HEDIS.
Use of Appropriate Medications for People with Asthma	✓	✓	✓	HEDIS 2006	Medicaid Provider File Required.
Medical Assistance with Smoking Cessation	✓	✓	NR	CAHPS 3.0H	
Follow-Up After Hospitalization for Mental Illness	✓	✓	NR	HEDIS 2006	Optional Medicaid Enhancement File.
Antidepressant Medication Management	✓	✓	NR	HEDIS 2006	Optional Medicaid Enhancement File.
Use of Imaging Studies for Low Back Pain	✓	✓	NR	HEDIS 2006	
Use of Spirometry Testing in The Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	✓	✓	NR	HEDIS 2006	New Measure.
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	✓	✓	NR	HEDIS 2006	New Measure.
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	✓	✓	✓	HEDIS 2006	New Measure.
Annual Monitoring for Patients on Persistent Medications	✓	✓	NR	HEDIS 2006	New Measure.
Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis	✓	✓	NR	HEDIS 2006	New Measure. Medicaid Provider File Required.
Adolescent Screening and Counseling Measures	✓	✓	✓	NYS-Specific	New Measures.
Access / Availability of Care					
Adult Access to Preventive/Ambulatory Care	✓	✓	NR	HEDIS 2006	
Children's Access to PCPs	✓	✓	✓	HEDIS 2006	
Prenatal and Postpartum Care	NR	NR	NR	HEDIS 2006	Rotated for 2005 reporting per HEDIS.
Annual Dental Visit	NR	✓	✓	HEDIS 2006	
Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	✓	NR	NR	HEDIS 2006	

NR: Not required

Table 1: 2005 QARR/HEDIS 2006 - Table of Required Measures					
Payer	**Commercial**	**Medicaid**	**CHPlus**	**Specifications**	**Additional Comments**
Measure			**Health Plan Stability**		
Practitioner Turnover	✓	✓	✓	HEDIS 2006	
Health Plan Descriptive Information					
Board Certification	✓	✓	NR	HEDIS 2006	
Enrollment by County	✓	✓	✓	NYS-Specific	Include Family Health Plus membership under Medicaid line of business.
Use of Services					
Well-Child Visits in the First 15 Months of Life	✓	NR	✓	HEDIS 2006	
Well-Child Visits in the 3rd, 4th, 5th & 6th Year	✓	NR	✓	HEDIS 2006	
Adolescent Well-Care Visits	✓	NR	✓	HEDIS 2006	
Frequency of Ongoing Prenatal Care	NR	NR	NR	HEDIS 2006	Rotated for 2005 reporting per HEDIS.
Frequency of Selected Procedures					
Myringotomy	✓	✓	✓	HEDIS 2006	
Tonsillectomy	✓	✓	✓	HEDIS 2006	
Dilation & Curettage	✓	✓	NR	HEDIS 2006	New Measure.
Hysterectomy, vaginal & abdominal	✓	✓	NR	HEDIS 2006	
Cholecystectomy, open & closed	✓	✓	NR	HEDIS 2006	
Back Surgery	✓	✓	NR	HEDIS 2006	New Measure.
Angioplasty (PTCA)	✓	NR	NR	HEDIS 2006	
Cardiac Catheterization	✓	NR	NR	HEDIS 2006	
Coronary Artery Bypass Graft (CABG)	✓	NR	NR	HEDIS 2006	
Prostatectomy	✓	NR	NR	HEDIS 2006	
Mastectomy	✓	✓	NR	HEDIS 2006	New Measure.
Lumpectomy	✓	✓	NR	HEDIS 2006	New Measure.
Inpatient Utilization	✓	✓	✓	HEDIS 2006	
Ambulatory Care	✓	✓	✓	HEDIS 2006	
Discharges and ALOS Maternity Care	✓	✓	NR	HEDIS 2006	
Births and ALOS Newborns	✓	✓	NR	HEDIS 2006	
Inpatient Mental Health Utilization	✓	✓	NR	HEDIS 2006	
Inpatient Chemical Dependency Utilization	✓	✓	NR	HEDIS 2006	
Identification of Alcohol and Other Drug Services	✓	NR	NR	HEDIS 2006	
Antibiotic Utilization	✓	NR	NR	HEDIS 2006	New Measure.
Satisfaction with the Experience of Care					
Satisfaction Survey	✓	DOH	DOH	CAHPS 3.0H	Commercial plans will submit CAHPS results. The Department will sponsor the Medicaid and Child Health Plus surveys.
NYS-Specific Prenatal and Postnatal Care Measures					
Risk-Adjusted Lowbirthweight	These prenatal care measures will be calculated by the Office of Managed Care using the birth data submitted by plans and the Department's Vital Statistics Birth File.				
Prenatal Care in the First Trimester					
Risk-Adjusted Primary Cesarean Delivery					
Access to Facilities for High-Risk Deliveries					

DOH: DOH will calculate
NR: Not required

I. Submission Requirements

2005 QARR consists of measures from the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data Information Set (HEDIS®) and NYS-specific measures. This version of QARR incorporates measures from HEDIS® 2006. The major areas of performance included in the 2005 QARR are:

1) Effectiveness of Care
2) Access to/Availability of Care
3) Satisfaction with the Experience of Care
4) Health Plan Stability
5) Use of Services
6) Health Plan Descriptive Information
7) NYS-specific Prenatal and Postpartum Care Measures

Who Must Report

- All managed care organizations certified by the New York State Department of Health (DOH) prior to 2005 must report all QARR measures for which there are enrollees meeting the continuous enrollment criteria.
- Plans certified during 2005 are required to submit **Enrollment by County**, along with any other measures that meet HEDIS eligibility criteria.

What to Report

Table 1 lists, by payer, the NYS-specific and HEDIS® 2006 measures required for submission. This manual describes in detail only the New York State-specific measures. Plans must purchase the HEDIS® 2006 technical specifications for descriptions of the required HEDIS® measures. Plans should always follow HEDIS® 2006 guidelines when calculating continuous enrollment periods.

Important Note: Only data for New York State enrollees should be included in the data used to calculate QARR measures.

Reporting by payer is as follows:

- **Commercial (CO)**: Measures required for commercial enrollees are found in Table 1.
  - Point of Service (POS): Follow HEDIS® 2006 instructions regarding commercial point-of-service products. Plans must state on the 2005 QARR Submission Cover Sheet whether POS is included in their rates (see Attachment 1) as well as indicate on the New York State Data Submission System (NYSDSS).
  - Live Birth file is required for submission.

- **Medicaid (MA)**: Measures required for Medicaid enrollees are found in Table 1.
  - The Chlamydia Screening and Well-Child and Preventive Care rates are calculated by DOH using data from the Medicaid Encounter Data System (MEDS). Rotated for 2005 reporting year.
  - Medicaid hybrid denominator files, Childhood Immunizations and Lead Screening file, Provider files, and Live Birth files are required. The Fee-For-Service Enhancement files are optional.

- **Family Health Plus**: Plans should include Family Health Plus enrollees in their Medicaid product line for the 2005 reporting year submission. Family Health Plus members should also be included in all Medicaid file submissions.

- **Child Health Plus (CHP)**: Measures required for Child Health Plus are found in Table 1 and should follow the commercial specifications. However, because CHP enrollment is monthly, plans will use the 30-day break in enrollment criterion.

- **Medicare**: With the exception of Enrollment by County, plans should **not** submit Medicare information.

Measure Rotation

The following HEDIS®/QARR measures will be rotated for the 2005 reporting year, according to the HEDIS® 2006 rotation schedule. Plans are not required to submit these measures for their commercial, Medicaid, or Child Health Plus populations. For reporting purposes, previous year's rates will be used for rotated measures.

- Cervical Cancer Screening
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Prenatal and Postpartum Care
- Frequency of Ongoing Prenatal Care

New Measure Requirements

As indicated on Table 1, the following measures are new QARR requirements for the 2005 measurement year:

- Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (CO, MA)
- Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (CO, MA)
- Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (CO, MA, CHP)
- Annual Monitoring for Patients on Persistent Medications (CO, MA)
- Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis (CO, MA)
- Frequency of Selected Procedures: Dilation & Curettage (CO, MA), Back Surgery (CO, MA), Mastectomy (CO, MA), Lumpectomy (CO, MA)
- Antibiotic Utilization (CO)
- Adolescent Screening and Counseling Measures (CO, MA, CHP)

Plans should follow HEDIS® 2006 specifications for reporting all these measures except the Adolescent Screening and Counseling measures, which are New York State-specific measures. This measure will be required for the Commercial, Medicaid and Child Health Plus product lines. The new specifications can be found beginning on page 9.

How to Report

All plans must submit QARR data on the New York State Data Submission System (NYS DSS), which will be sent directly to plans by IPRO. Estimated completion date for the 2005 NYS DSS is March 2006.

Where to Report

The FFS enhancement files, Medicaid hybrid denominator files, Childhood Immunizations, Lead Testing files, Provider files and the commercial and Medicaid Live Birth files (all due June 15, 2006) should be sent to:

Paul Henfield
IPRO
1979 Marcus Avenue
Lake Success NY 11042-1002

The completed QARR submission, including commercial CAHPS results, should be sent by June 15, 2006 to:

Susan Anderson
Bureau of Quality Management and Outcomes Research
Office of Managed Care
New York State Department of Health
Rm. 1864 ESP Corning Tower
Albany NY 12237-0094

Please remember to include the cover sheet labeled as Attachment 1 as part of your QARR submission.

Questions

Questions concerning the 2005 submission should be directed to the following individuals:

- **Data Submission System (DSS):**
  Lisa Balistreri of IPRO at (516) 326-7767 ext. 357

- **HEDIS® 2006 measures:** NCQA - (202) 955-3500. Updates can be found on NCQA's web site: www.ncqa.org

- **All other questions:** Jackey Matson (jmb10@health.state.ny.us) and Raina Josberger (rej03@health.state.ny.us) of NYSDOH at (518) 486-9012.

II. Audit Requirements

- HMOs must contract with an NCQA-certified auditor for a full audit of their commercial and if applicable, Medicaid and CHP QARR data.

- The Prepaid Health Services Plans (PHSPs) will be participating in a department-sponsored audit conducted by IPRO.

- Plans that serve CHP enrollees must include the CHP population in the audit. When applicable, the department-sponsored audit of the PHSPs will include CHP.

- Non-PHSPs must send a copy of the written agreement with an independent auditor to the following address by **March 1, 2006.**

Susan Anderson
Bureau of Quality Management & Outcomes Research
Office of Managed Care
New York State Department of Health
Rm. 1864 ESP Corning Tower
Albany NY 12237-0094

- It is recommended that health plans provide a draft version of the NYS DSS to their independent auditor along with the Medicaid enhancement files, Medicaid denominator files, and commercial and Medicaid birth files prior to the June 15 deadline (Recommended by June 1, 2006). Auditors should check for accuracy and that the specified variables in these files and the NYS DSS correspond.

- **A copy of the Audit Designation Table (from the NYS DSS) must be submitted to the Office of Managed Care with your QARR submission by June 15, 2006.** A copy of the report of Final Audit Findings, including identified problems, corrective actions and measure-specific results, must be submitted to the Office of Managed Care upon receipt from your auditor (due to the Office of Managed Care by **July 31, 2006**). The final audit report must contain audit validation signatures.

- The Office of Managed Care requires plans to submit data for all measures for which there is an eligible population. Plans may not designate a measure as 'NR--plan chose not to report this measure'.

III. Reporting Schedule

Table 2: The following table includes due dates and destinations for the various components of the QARR submission.

Submission Requirement	HMOs		PHSPs	
	Due Date	**Destination**	**Due Date**	**Destination**
• For non-PHSPs, a copy of a written agreement with an independent auditor. (Indicate that CHPlus is included in the audit, if applicable.)	March 1, 2006	NYSDOH	N/A	N/A
• 2005 QARR Submission Cover Sheet • Data Submission System (DSS) diskette (For all plans, the first version of the DSS is due to auditors 2 weeks prior to submission deadline to NYS) • Hard copy of 2005 QARR DSS submission, including the name(s) and phone number(s) of individuals to contact with questions • Audit Designation Table (Commercial, Medicaid, & CHPlus), printed as part of the 2005 NYS DSS	June 1, 2006 June 15, 2006	Auditor NYSDOH	June 1, 2006 June 15, 2006	IPRO NYSDOH
• Medicaid Enhancement Files • Medicaid Adult Health Denominator Files • Medicaid Provider Files • Birth Diskette (Commercial & Medicaid) For all plans, DOH recommends that the first version of the DSS be sent to auditors 2 weeks prior to the submission deadline to NYSDOH. Auditors will compare Diskettes to DSS for accuracy before they lock the DSS.	June 1, 2006 June 15, 2006	Auditor IPRO	June 1, 2006	IPRO
• Commercial CAHPS Survey (plans must instruct CAHPS Survey vendors to submit a diskette containing enrollee-specific data following NCQA specifications to NYSDOH).	June 15, 2006	NYSDOH	June 15, 2006	NYSDOH
• Full report of Final Audit Findings, including identified problems, corrective actions and measure-specific results containing original validation signatures.	July 31, 2006	NYSDOH	N/A	N/A

IV. New York State-Specific Measures

ADOLESCENT SCREENING AND COUNSELING MEASURES
Commercial, Medicaid, and Child Health Plus

Description

The percentage of adolescents ages 14 to 18 who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year, receiving the following six components of care during the measurement year:

1. Body Mass Index (BMI) screening,
2. Assessment or counseling or education on nutrition **and** exercise,
3. Counseling or education on risk behaviors associated with sexual activity and preventive actions,
4. Assessment for depression,
5. Assessment or counseling or education about the risks of tobacco usage, and
6. Assessment or counseling or education about the risks of substance use (including alcohol and excluding tobacco).

Note:

- The MCO may count services that occur over multiple visits toward this measure as long as all services occur within the timeframe established in the measure.

Eligible Population

Product lines: Commercial, Medicaid, and Child Health Plus

Age: Adolescents 14 to 18 years old as of December 31, 2005

Continuous Enrollment: The measurement year (Jan. 1 – Dec. 31, 2005)

Allowable Gap: For Commercial, the member may have no more than one gap in enrollment of up to 45 days during the measurement year. For Medicaid and Child Health Plus, the member may not have more than a 1-month gap in coverage.

Anchor Date: Enrolled as of December 31 of the measurement year.

Event: Administrative data of at least one well care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. The primary care practitioner does not have to be assigned to the member. Adolescents who had a claim or encounter with a primary care practitioner or OB/GYN practitioner with one of the codes listed below are considered to have received a well care visit. (Table AWC-A: Codes to Identify Adolescent Well-Care Visits from HEDIS® 2006, Volume 2, pg 249).

CPT Codes	ICD-9-CM Codes
99383 – 99385, 99393 - 99395	**V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9**

Denominator
A systematic sample drawn from the MCO's eligible population. The measure will be based on 100 eligible members for the first year of collection. In subsequent reporting years, the sample will be based on 411 members. If the eligible population is less than 100, the entire eligible population should be used.

Random Number (RAND) for the Adolescent Screening and Counseling Measures

Measure	RAND
Adolescent Screening And Counseling Measures	.44

Note:

- The MCOs should follow HEDIS® guidelines for over sampling and substitutions for replacing exclusions (Substituting Medical Records and Hybrid Methodology from HEDIS® 2006, Volume 2, pg 60-63).

Exclusions
Pregnant members are excluded from the denominator. Exclusions must be identified with both administrative data and medical record review.

Administrative Exclusions: Pregnant members may be identified using administrative codes (Tables PPC-A: Codes to Identify Live Births, PPC-B: Codes to Identify Deliveries and Verify Live Births, PPC-C: Markers for Early Prenatal Care Obtainable from Administrative Data, PPC-D: Markers for Prenatal Care Obtainable from Administrative Data, and PPC-E: Codes to Identify Postpartum Visits from HEDIS® 2006, Volume 2, pg 190-197).

Medical Record Exclusions: Members found to have pregnancy related care, beyond a test for pregnancy, should be removed from the denominator. The pregnancy could have occurred any time during the measurement year.

Screening Tools
Notation that a particular tool was used without noting which areas were assessed, counseled or discussed, would not be a positive numerator finding. If a checklist is used and included or there is a reference to the areas covered, the notations would be positive numerator events. For example, a notation that AMA GAPS was done would not be acceptable. If the notation stated the tool was used and activity/diet, sexual activity, mental health, tobacco and substance use were reviewed; these would be considered positive numerator findings for the five topic areas.

Numerator 1: Screening for a Weight Issue Using Body Mass Index (BMI)
Documentation in the medical record of a BMI **or** BMI percentile during the measurement year. Any of the following elements are positive findings:

- Notation of BMI calculation in the medical record
- Notation of BMI percentile in the medical record

- Notation of BMI on graph
- Notation of BMI percentile on graph.

Numerator 2: Assessment or Counseling or Education on Nutrition and Exercise
Documentation in the medical record of **nutrition** assessment or counseling or education being provided during the measurement year **and exercise** assessment or counseling or education being provided during the measurement year. Any of the following elements are positive findings:

- Notations of assessment of current behaviors (e.g. eating habits, exercise routine, participation in sports activities, etc.)
- Use of a checklist indicating both topics were addressed
- Notation of counseling or referral (includes community programs known to address both nutrition and activity, such as Weight Watchers)
- Distribution of educational materials to the member, specifically geared towards nutrition and exercise
- Notation of "anticipatory guidance" for nutrition and exercise

Note:

- Documentation of assessment and counseling in one area alone is not a positive numerator. For example, assessment of nutrition and counseling of exercise would qualify as a numerator event. However, assessment and counseling of nutrition and no notation of exercise would not qualify as a positive numerator.

Numerator 3: Counseling or Education on Risk Behaviors Associated with Sexual Activity and Preventive Actions
Documentation in the medical record of counseling or education on preventive actions and risk behaviors associated with sexual activity during the measurement year.

Discussion on abstinence, family planning, condom use, contraceptives, HIV, STDs, pregnancy prevention, and safe sex are positive findings. The documentation can include:

- Use of a checklist indicating any of the above noted topics were discussed
- Notation of counseling or referral for treatment or testing for HIV/STDs
- Notation of a prescription or dispensing for contraceptives
- Distribution of educational materials to the member, specifically geared towards risk behaviors and preventive actions

Note:

- A pregnancy test alone or an STD or HIV test alone, without any of the above mentioned documentation, is not a positive finding for this numerator.

Numerator 4: Assessment for Depression
Documentation in the medical record of an assessment for depression during the measurement year. The documentation can include**:**

- Notation from a health assessment about the adolescent's depressive symptoms during the measurement year
- Use of a checklist indicating that the topic was addressed
- Inquiry of depression (e.g. "denies depression", "depression – none", "depression-yes

or no")

- Inquiry as to whether the member felt down, depressed, or hopeless
- Inquiry as to whether the member felt little interest or pleasure in doing things
- Notation of the mental health status and/or suicide ideation
- Notation of counseling or referral for treatment
- Discussion of antidepressant medications

Note:

- A prescription for antidepressants without any of the above mentioned documentation, is not a positive finding for this numerator.

- Notations of members in treatment for depression would be positive findings if the treatment occurred during the measurement year. Mental health treatment needs to be for depression. A notation of Mental Health care for other conditions, such as ADHD, does not indicate a depression screen.

Numerator 5: Assessment or Counseling or Education About the Risks of Tobacco Usage

Documentation in the medical record of assessment or counseling or education about the risks of tobacco use during the measurement year. Tobacco use includes, but is not limited to, cigarettes, chew, or cigars. The following elements are positive findings:

- Notations about current or past behavior regarding tobacco use
- Use of a checklist indicating topic was addressed
- Notation of counseling or treatment referral
- Notation of prescription for smoking cessation medication
- Distribution of educational materials to the member, pertaining to tobacco use
- Notation of "anticipatory guidance" for tobacco use
- Notation of discussion of exposure to secondhand smoke

Numerator 6: Assessment or Counseling or Education About the Risks of Substance Use (Including Alcohol and Excluding Tobacco Use)

Documentation in the medical record of an assessment or counseling or education about the risks of substance use during the measurement year. Substance use includes, but is not limited to, alcohol, street drugs, non-prescription drugs, prescription drugs, and inhalant use. The following elements are positive findings:

- Notations about current or past behavior regarding substance use/alcohol use
- Use of a checklist indicating topic was addressed
- Notation of counseling or treatment referral
- Distribution of educational materials to the member pertaining to substance and/or alcohol use (not tobacco)
- Notation of "anticipatory guidance" for substance use

Note:

- Documentation of assessment and counseling for one area alone is a positive numerator. For example, notations that address only alcohol or only drug use would still be positive numerator findings.

LEAD TESTING
Commercial/Medicaid/Child Health Plus

Description

The percentage of Medicaid, commercial and Child Health Plus program members with a second birthday during the reporting year who received a **capillary or venous blood test for lead poisoning by the end of the child's 25th month of life**. The time period during which lead testing may be provided is extended to 25 months in order to be consistent with the Child Teen Health Plan visit schedule which recommends a wellness visit at 23-25 months of age. *For example, if the child's second birthday occurs on July 4, the child's 25th month of life extends from July 5 through August 3. The lead screening must have occurred on or before August 3 for this child to be included. Dates of service occurring after August 3 do not count toward the numerator.*

Measure Specifications

Denominator Requirements: The samples will be exactly the same for Childhood Immunization and Lead Testing. See HEDIS specifications for Childhood Immunization, including reducing sample size. If a child is excluded from the childhood immunization denominator, then he/she is excluded from the lead testing denominator.

Numerator Requirements: The number of enrollees in the denominator who received a capillary or venous blood test for lead poisoning by the end of their 25th month of life. The end of the child's 25th month of life is defined as the 30 days immediately following the child's second birthday. Refer to the Administrative Data Specification and Hybrid Method Specification sections below for specific criteria on identifying numerator positives.

> ***Administrative Data Specification:*** Children in the denominator identified as having had a lead test through a submitted claim/encounter with CPT-4 code 83655 and a date of service on or before the end of the child's 25th month of life.
>
> ***Hybrid Method Specification:*** Children in the denominator whose medical record contains a dated copy of at least one lead test result performed and recorded by the end of the child's 25th month of life. If the lead test was performed by the child's 25th month of life, but the result was not recorded until after the child's 25th month of life, the child can be included in the numerator.
>
> *Any medical record documentation, including laboratory slips, is sufficient, provided it includes all of the following:*
>
> - *child's name*
> - *the child's date of birth (A notation of the child's age is not sufficient evidence of date of birth.)*
> - *date test was performed*
> - *result of test*
>
> *NOTE: Results of Erythrocyte Protoporphyrin testing are unacceptable.*

The following prenatal care performance measures will be calculated by the Office of Managed Care using the birth data submitted by plans and the Department's Vital Statistics Birth File.

- Risk-Adjusted Low Birthweight Rate
  The adjusted rate for infants with birth weights less than 2500 grams. Only live births are used in this analysis.
- Prenatal Care in the First Trimester
  The rate of continuously (ten months or more) enrolled women with a live birth who had their first prenatal care visit in the first trimester, defined as a prenatal care visit within 90 days of the date of last normal menses. For this analysis, the first prenatal care visit is defined as the date of the first physical and pelvic examinations performed by a physician, nurse practitioner, physician's assistant and/or certified nurse midwife at which time pregnancy is confirmed and a prenatal care treatment regimen is initiated.
- Risk-Adjusted Primary Cesarean Delivery Rate
  The adjusted percentage of live infants delivered by cesarean to women who had no prior cesarean deliveries. The denominator is the total number of live births delivered vaginally and by primary cesarean delivery.
- Low Birthweight Deliveries at Facilities for High-Risk Deliveries and Neonates
  The percentage of women delivering a live low birthweight or very low birthweight baby at a high-risk facility (Perinatal Care Level II/III/IV).

Calculation of the Measures

Upon receipt of the list of mothers who gave birth during **the measurement year (January 1, 2005 through December 31, 2005)*** DOH staff will employ a multistage matching algorithm to link information provided by plans to the Vital Statistics Birth File. Risk-adjustment models will also be used to calculate low birthweight and cesarean delivery rates. Using the data submitted by the plans, and the Department's Vital Statistics Birth File, risk factors or confounding factors such as race, age, plurality, education level and complications of labor and delivery will be used to construct a predictive model. Risk-adjusted rates are more comparable across plans because the methodology takes into account that these risk factors are beyond the plans control.

The Vital Statistics File provides information on the first prenatal care visit, the number of visits, birthweight, type of delivery, age, race, level of education and maternal risk factors associated with labor and delivery. Matching plan data to the birth certificate data improves the data reporting by allowing for: 1) the calculation of performance measures using the same DOH data source, and, 2) the risk adjustment of the measures when applicable.

Please note that this differs from prior years where the HEDIS timeframe was used.

Reporting Requirements

Plans are to report all live births during the period of **January 1, 2005 to December 31, 2005** to the Office of Managed Care. Information provided will be used to link to the Vital Statistics Birth File. The following information is required for this linking process to be successful:

- Mother's Last Name: (List mother more than once in cases of multiple births.)
- Mother's First Name
- Mother's Date of Birth
- Mother's Resident Zip Code at Time of Delivery
- Date of Delivery. (The date of delivery is a critical field for matching to the Department's Vital Statistics Birth File. The mother's admission date is not on the Vital Statistics Birth File, nor is it necessarily the same as the date of delivery. However, if the date of delivery is truly unavailable, the Office of Managed Care will use the mother's admission date to obtain the highest match rate possible.)
- Hospital of Delivery (PFI). (A list of current hospital PFI codes appears on the Health Provider Network To access the listing, go to the HPN Main Page, select Programs, Office of Managed Care, Provider Network Data Systems, Lookups-Operating Facility Codes, Hospital Listing. If delivery occurred at a Birthing Center a valid PFI can be found in the Diagnostic & Treatment Centers (clinics) file, also under Operating Facility Codes.)
- Mother's Date of Admission
- Number of Enrollment Days Prior to Delivery
- Most Recent Enrollment Date
- Most Recent Disenrollment Date
- Mother's Medicaid ID Number

The plan's data will be formatted on a CD/diskette as described in the following reporting Specifications:

Format: Standard ASCII file with all entries left justified unless otherwise indicated.

Medicaid: Submit one diskette containing Medicaid members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-97.
Commercial: Submit one diskette containing commercial members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-89.

Eligible Group

The eligible group will include all deliveries resulting in live births, to New York State residents occurring during the period of January 1, 2005 to December 31, 2005. Identify the women who had at least one live birth during the measurement period for whom the plan is the primary payer. Please follow HEDIS® 2006 Technical Specifications for identification of the eligible group. Plans using the New York State AP-DRGs should use the following codes to identify deliveries.

Description	Federal DRGs	NYS AP-DRGs
Identify Live Births	370-375	370-375, 650-652

Further identification of deliveries and verification of live births should be done using the ICD-9-

CM diagnosis codes and CPT procedure codes according to HEDIS 2006 specifications.

Record Format for Medicaid and Commercial

Element Name	Location	Coding	Notes
Mother's Last Name	1-20	Left Justified	No numeric entries. List mother more than once in the case of multiple births.
Mother's First Name	21-35	Left Justified	Do not include middle initial or punctuation
Mother's Date of Birth	36-43	DDMMYYYY	Year must include four digits (e.g., 2005)
Mother's Resident Zip Code at Time of Delivery	44-48	Right Justified	No blanks, use 99999 if unknown
Date of Delivery	49-56	DDMMYYYY	Year must include four digits (e.g., 2005)
Hospital of Delivery	57-61	Left Justified	Please use 88888 for 'out of state': 99999 for 'unknown hospital'; and 11111 for 'not in hospital' birth. *PFI numbers for birth centers are now available, see note below for coding these facilities.* **If using a four digit PFI*, it must be LEFT justified. Do not add a leading zero.**
Mother's Date of Admission	62-69	DDMMYYYY	Year must include four digits (e.g., 2005)
Number of Enrollment Days Prior to Delivery	70-73	Right Justified	Number of days that the mother was enrolled in the plan during the 12 month period immediately prior to delivery. Cannot be a negative number.
Most Recent Enrollment Date	74-81	DDMMYYYY	Most recent enrollment date prior to delivery. Do not count the annual renewal date as the Most Recent Enrollment Date if already enrolled.
Most Recent Disenrollment Date	82-89	DDMMYYYY	Most recent disenrollment date prior to delivery. If there is no disenrollment date, enter 99999999. Enrollment and Disenrollment Dates are requested to indicate any break in prenatal care while in the managed care plan.
Mother's Medicaid ID Number	90-97	AA#####A	Omit for commercial; it is not applicable. (Medicaid only)

Important Note: A list of current hospital PFI codes appears on the Health Provider Network (HPN). To access the listing, go to the HPN Main Page, select Programs, Office of Managed Care, Provider Network Home Page, Operating Facility Codes, Hospitals – Updated October, 2005. *Valid birth center PFI codes can be found in the Diagnostic & Treatment Centers (clinics) file, also under the Operating Facility Codes page.*

Header Record: To be submitted in standard ASCII format as the first record on the disk.

HEADER FORMAT:

Element	Location	Coding
Plan Name	1-20	First 20 characters of plan name including blanks - Left justified
Number of deliveries on diskette	21-25	Right justified
Date diskette written	26-33	DDMMYYYY

Technical Assistance: If you need clarification of prenatal data requirements and/or assistance in creating a flat ASCII file, please contact Raina Josberger at (518) 486-9012.

ENROLLMENT BY COUNTY
All Payors

Data Collection Specifications

Plans will report the number of enrollees per payer type in the plan as of **December 31, 2005**. Each member is to be reported only once regardless of duration of enrollment. The enrollee's county of residence as of **December 31, 2005** should be used for designation of county. The enrollee may be included in only one of the following categories, also determined through the member's status as of **December 31, 2005.**

- Commercial Point of Service (POS)
- Commercial/HMO Only
- Direct Pay
- Medicare Risk
- Medicaid (*include Family Health Plus*)
- Child Health Plus

"Commercial/HMO Only" includes large and small group plans and individual policies. "Direct Pay" enrollment includes members covered under individual direct payments contracts consistent with the provisions of Chapter 501 of the Laws of 1992. COBRA conversions should not be included in direct pay enrollment.

Data Collection Tool

Plans will report data on the 2005 QARR NYS DSS.

V. Medicaid File Submissions

Medicaid Denominator Files, Optional Enhancements, and Provider Files

The Office of Managed Care (OMC) will be evaluating select measures using the Medicaid Encounter Data System and member-level data. Additionally, applicable measures will be evaluated using fee-for-service data to determine whether out-of-plan services were used by enrollees and would possibly impact plan rates. Client Identification Numbers (CINs) should be submitted for these enrollees included in the denominator for the measures specified below. OMC will also be collecting provider-level data for selected QARR 2005 administrative measures. Medicaid plans will be required to submit primary care provider (PCP) identification information for each individual in the denominators for the measures noted below. The OMC will use this information to explore the feasibility of calculating selected QARR rates by provider.

Measure	Denominator File	Enhancements	Provider File
Appropriate Treatment for Children with Upper Respiratory Infection			✓
Appropriate Testing for Children with Pharyngitis			✓
Cholesterol Management for Patients with Cardiovascular Conditions	✓		
Use of Appropriate Medications for People with Asthma			✓
Antidepressant Medication Management		✓	
Follow-up After Hospitalization for Mental Illness		✓	
Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis			✓
Adolescent Screening and Counseling Measures	✓		

Medicaid Denominator Files (Required)

For these hybrid measures, please submit a separate file for each, listing all the recipients included in the denominator along with an indicator showing whether each was included in the numerator, according to the following layout.

- Eligible members in the denominator should only be counted once.
- Plans should check for duplicate members in the diskette prior to submission.
- Conduct edit checks to make sure the denominator file matches the aggregate denominator and numerator reported in the NYS DSS.
- Plans should provide these materials to their auditor for comparison prior to the auditor lock of the DSS.
- The OMC Plan Identification number must be included for each member included in the denominator; this number can be referenced from the NYS DSS.
- The data must be saved as a file with a PRN file extension; dates must be YYYYMMDD.

Include these files on a separate diskette or CD-ROM. Plans are required to submit these denominator files for their Medicaid product lines.

Measure	Data Elements – MEDICAID ONLY	Fields	File Name
Cholesterol Management for Patients with Cardiovascular Conditions	OMC Plan ID (Refer to NYS DSS)	1-7	Cholesterol.prn
	CIN	8-15	
	Included in Numerator for LDL-C Screening? (1=Yes; 0=No)	16	
	Included in Numerator for LDL-C < 130 mg/dl? (1=Yes; 0=No)	17	
	Included in Numerator for LDL-C < 100 mg/dl? (1=Yes; 0=No)	18	
Adolescent Screening and Counseling Measures	OMC Plan ID (Refer to NYS DSS)	1-7	AdolScrCns.prn
	CIN	8-15	
	Included in Numerator1 for BMI? (1=Yes; 0=No)	16	
	Included in Numerator2 for Nutrition and exercise? (1=Yes; 0=No)	17	
	Included in Numerator3 for Sexual activity and Preventive actions? (1=Yes; 0=No)	18	
	Included in Numerator4 for Depression? (1=Yes; 0=No)	19	
	Included in Numerator5 for Tobacco usage? (1=Yes; 0=No)	20	
	Included in Numerator6 for Substance use? (1=Yes; 0=No)	21	

Medicaid Enhancements (Optional)

Client Identification Numbers (CINs) for the following measures should be submitted for those enrollees included in **denominator** for plans wishing to have applicable measures screened for out-of-plan services. The submission of these enhancement files is optional.

- **Antidepressant Medication Management – Optimal Practitioner Contacts for Medication Management**: In order to be considered a numerator "hit", three or more visits must be found. If you would like the Office of Managed Care to evaluate Medicaid fee-for-service (FFS) data to determine whether out-of-plan services were used for this component of the measure, in addition to the Client Identification Number (CIN), please include: the index episode start date and subsequent visit dates. If no visits were found for a CIN, the indicator (0) should be entered and the dates should be zero filled. In addition, please include an indicator (1=Yes; 0= No) whether each CIN was included in the 84 Day Acute Treatment Phase (Numerator 2) and the 180 Day Effective Treatment Phase (Numerator 3) calculations. These indicators will be used for internal data validation purposes only. Plans should check for duplicate members in the diskette prior to submission.

- **Follow-Up After Hospitalization for Mental Illness:** There are two time periods in which a follow-up visit must have taken place in order to be considered a numerator “hit”; up to seven

days after hospital discharge, and up to 30 days after discharge. If you would like the Office of Managed Care to evaluate Medicaid FFS data to determine whether out-of-plan services were used for either of these components of the measure, in addition to the CIN, please include: the date of the 7-day follow-up visit, and the date of the 30-day follow-up visit. If there is a 7-day follow-up visit, but no visit between 8 and 30 days after discharge, please duplicate the date of the 7-day visit for the 30-day visit. If no visits were found for a CIN, enter zeros for both visit date fields.

For the following Medicaid measures, please submit a separate file for each measure, listing all recipients included in the denominator, according to the following layout. Please note that the OMC Plan Identification number must be included for each member included in the denominator.

This ID number can be referenced from the NYS DSS. Please also note that the data must be saved as a file with a PRN file extension; dates must be YYYYMMDD. Incorrectly submitted files (e.g., incorrect number of CINs) may not be processed for enhancements.

Conduct edit checks to make sure the denominator file matches the aggregate denominator and numerator reported in the NYS DSS. Plans should provide these materials to their auditor for comparison prior to the auditor lock of the DSS.

Measure	Data Elements Needed	Fields	File Name
Antidepressant Medication Management: **1) Optimal Practitioner Contacts,** **2) 84 Day Acute Phase, and** **3) 180 Day Effective Phase Treatment**	OMC Plan ID (Refer to NYS DSS) CIN Included in Numerator 1? (1=Yes; 0=No) Index Episode Start Date (YYYYMMDD) Subsequent Visit Date1 (YYYYMMDD) Subsequent Visit Date2 (YYYYMMDD) Subsequent Visit Date3 (YYYYMMDD) Included in Numerator 2? (1=Yes; 0= No) Included in Numerator 3? (1=Yes; 0=No)	1-7 8-15 16 17-24 25-32 33-40 41-48 49 50	Antidep.prn
Follow-Up After Hospitalization for Mental Illness: **1) 7 Day and** **2) 30 Day**	OMC Plan ID (Refer to NYS DSS) CIN Discharge Date (YYYYMMDD) 7-Day Follow-up Visit Date (YYYYMMDD) 30-Day Follow-up Visit Date (YYYYMMDD)	1-7 8-15 16-23 24-31 32-39	Followup.prn

Plans will be advised of their updated rates subsequent to the incorporation of out-of-plan numerator events.

Medicaid Provider Files – (Required)

Provider information should be submitted for the following administrative measures:

- Use of Appropriate Medications for People with Asthma
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis

Please submit a separate file for each measure, listing the Medicaid Client Identification Number (CIN) for all recipients included in the denominator, an indicator showing whether the CIN is included in the numerator, PCP MMIS number, PCP license number and PCP last name according to the following layout. (More PCP identifiers will result in more complete information and analyses.)

Measure	Data Elements – MEDICAID ONLY	Fields	File Name
Use of Appropriate Medications for People with Asthma	OMC Plan ID (Refer to NYS DSS)	1-7	Asthma.prn
	Medicaid Client Identification Number (CIN)	8-15	
	Included in Numerator? (1=Yes, 0=No)	16	
	Provider MMIS Number	17-24	
	Provider License Number	25-30	
	Provider Last Name	31-55	
Appropriate Treatment for Children with URI	OMC Plan ID (Refer to NYS DSS)	1-7	URI.prn
	Medicaid Client Identification Number (CIN)	8-15	
	Included in Numerator? (1=**RECEIVED AN ANTIBIOTIC, 0=No)**	16	
	Provider MMIS Number	17-24	
	Provider License Number	25-30	
	Provider Last Name	31-55	
Appropriate Testing for Children with Pharyngitis	OMC Plan ID (Refer to NYS DSS)	1-7	Pharyngitis.prn
	Medicaid Client Identification Number (CIN)	8-15	
	Included in Numerator? (1=Yes, 0=No)	16	
	Provider MMIS Number	17-24	
	Provider License Number	25-30	
	Provider Last Name	31-55	
Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis	OMC Plan ID (Refer to NYS DSS)	1-7	Bronchitis.prn
	Medicaid Client Identification Number (CIN)	8-15	
	Included in Numerator? (1=**RECEIVED AN ANTIBIOTIC, 0=No)**	16	
	Provider MMIS Number	17-24	
	Provider License Number	25-30	
	Provider Last Name	31-55	

Be aware that for the Appropriate Treatment for Children with URI measure, we are asking you to identify those children in the denominator that were prescribed an antibiotic. As with the NYS DSS, you do not need to invert the numerator.

To ensure that all Denominator, Enhancement and Provider files are accurate please:

- Eliminate duplicate CINS (with the exception of Follow-up After Hospitalization);
- Conduct edit checks to make sure the number of CINS in the denominators and numerators matches the aggregate denominators and numerators reported in the NYS DSS;
- Provide these materials to your auditor for comparison prior to locking the NYS DSS;
- Obtain the OMC Plan Identification Number from the NYS DSS; and,
- Save the files in a fixed-length format with a PRN file extension.

Childhood Immunization

Description of Changes

The following changes are requested for this year's Childhood Immunization diskettes:

- The number of antigens has been reduced to the number required for a numerator positive according to HEDIS® specifications. For example, instead of 6 DTP dates, plans can only report 4 this year.
- Plans should first include all immunizations that qualify the child as a numerator positive, and secondly, any other immunizations that do not meet HEDIS specifications.
- **All dates should be provided in sequential chronological order.**
- Dates of all diseases contracted by the child should be reported.
- Plans must indicate the **total number** of lead tests a child received.

OMC is requesting that plans submit antigen dates of services in accordance with the following methodology:

- Submit all vaccine events as date of services that qualify the child as a numerator positive in chronological order.
- If fewer than the required number of antigens are identified, submit each vaccine event as a date of service in chronological order regardless of compliance with the HEDIS measure. This additional information will be used for quality improvement and research.

PLEASE NOTE: Plans are still required to calculate HEDIS rates for Childhood Immunization Status to be submitted to the NYS DOH in aggregate on the NYS DSS.

Eligible Group

Plans should follow the HEDIS 2006 specifications for Childhood Immunization Status when defining the eligible population.

The sample on the Medicaid Immunization diskette **must** match the denominator submitted for Childhood Immunization Status and Lead Testing on the NYS DSS. The same sample must be used for Childhood Immunization and Lead Testing. If a child is excluded from the denominator of Childhood Immunization, then he/she should also be excluded from the Lead Testing denominator.

Numerator Specification
Plans should report all immunizations that qualify the child as a numerator positive first, and then all immunizations administered prior to, after, and including the child's second birthday, regardless of the number of vaccinations and dates of administration (e.g., all 4 DTP dates that qualify the child as a numerator positive, and if the child does not have all 4 that qualify him/her, include all dates of administration of the DTaP/DT vaccinations, regardless of timing).

Plans may use information obtained from the New York City and upstate Immunization Registries.

For all antigens, the MCO may count evidence of any of the following if a date is documented:

- Evidence of the antigen, or
- Documented history of the illness, or
- A seropositive test result.

Exclusions
Plans should follow HEDIS 2006 specifications for children with contraindications.

Reporting
A standard ASCII file with the following elements left justified must be submitted. Please zero fill incomplete antigen series for date of disease fields that are not applicable. All dates within a numerator should be in sequential order. For example, if a child had two DTP's, the earlier date should be reported in the first column, and the more recent date should be reported in the second column.

Check that the file does not contain duplicate members before submitting the data. The denominator and numerators should match the values submitted in the DSS.

Element	Record Position	Field Format
OMC Plan ID (Refer to NYS DSS)	1-7	#######
Child's Medicaid Number (CIN)	8-15	AA#####A
Date of Birth	16-23	YYYYMMDD
Date of DTaP/DT 1	24-31	YYYYMMDD
Date of DTaP/DT 2	32-39	YYYYMMDD
Date of DTaP/DT 3	40-47	YYYYMMDD
Date of DTaP/DT 4	48-55	YYYYMMDD
Date of disease Diphtheria	56-63	YYYYMMDD
Date of disease Tetanus	64-71	YYYYMMDD
Date of disease Pertussis	72-79	YYYYMMDD
Date of IPV 1	80-87	YYYYMMDD
Date of IPV 2	88-95	YYYYMMDD
Date of IPV 3	96-103	YYYYMMDD
Date of disease IPV	104-111	YYYYMMDD
Date of MMR 1	112-119	YYYYMMDD
Date of disease Measles	120-127	YYYYMMDD

Date of disease Mumps	128-135	YYYYMMDD
Date of disease Rubella	136-143	YYYYMMDD
Date of HiB 1	144-151	YYYYMMDD
Date of HiB 2	152-159	YYYYMMDD
Date of HiB 3	160-167	YYYYMMDD
Date of disease HiB	168-175	YYYYMMDD
Date of Hepatitis B 1	176-183	YYYYMMDD
Date of Hepatitis B 2	184-191	YYYYMMDD
Date of Hepatitis B 3	192-199	YYYYMMDD
Date of disease Hepatitis B	200-207	YYYYMMDD
Date of VZV	208-215	YYYYMMDD
Date of disease VZV	216-223	YYYYMMDD
Date of pneumococcal conjugate 1	224-231	YYYYMMDD
Date of pneumococcal conjugate 2	232-239	YYYYMMDD
Date of pneumococcal conjugate 3	240-247	YYYYMMDD
Date of pneumococcal conjugate 4	248-255	YYYYMMDD
Number of Lead Tests (e.g., 0, 1, 2, 3, 4)	256	Numeric

Each record will have 256 characters with **no spaces** between fields or elements. The following is an example of a valid record.

1234567AA12345B2003030520030428200403222004082520041027000000000000000000
00000000000000000000000200309122003102520040301200406112004062020040825200310272004030820040428000000002003052820041002200410290000000020041115200410152004050520040829200410122004123 13

Any missing or not applicable dates should be submitted as zeros in the YYYYMMDD format (00000000).

Technical Assistance: If you need clarification on these files, please contact Jackey Matson at (518) 486-9012.

VI. Federal DRGs and NYS All Patient DRGs (AP-DRGs)

Table 3 on the next page has been developed to assist health plans with HEDIS measure specifications that refer to federal Diagnosis Related Groups (DRGs).

New York State's version of federal DRGs is referred to as the All Patient Diagnosis Related Groups (AP-DRGs) and was developed by the New York State Department of Health and 3M Health Information Systems.

Although both federal DRGs and New York State's AP-DRGs are assigned to appropriate Major Diagnostic Categories (MDCs) based upon principal diagnosis, AP-DRG assignment is not always a direct match with a federal DRG assignment. There are AP-DRG codes with no federal DRG equivalent. Therefore, a "direct crosswalk" is not possible between these two classification systems.

HEDIS measures with an inpatient component refer to the federal grouper for DRG assignment. Plans using the New York State-specific grouper and AP-DRGs should be aware of differences that may exist between the two groupers. Table 3 lists those HEDIS measures with DRGs included in the specifications and the corresponding AP-DRGs.

NYS DOH is not responsible for the interpretation of HEDIS specifications or updating HEDIS information. Plans should always refer to HEDIS specifications when calculating HEDIS measures as part of QARR.

Questions on technical updates to federal DRGs in the current version of HEDIS should be directed to NCQA at www.ncqa.org or 1-888-275-7585. For further information on AP-DRGs or how to purchase the updated grouper software, plans can contact the department's Division of Health Care Financing at (518) 474-6350

Table 3. AP-DRGs for HEDIS measures with DRGs included in the specifications

Measure	Description	NYS AP-DRG
Effectiveness of Care		
Antidepressant Medication Management	Major Depression	426
	Prior Depressive Episodes	426
Beta Blocker Treatment After Heart Attack	AMI	121, 122, 808, 853
Persistance of Beta Blocker Treatment After Heart Attack	AMI	121, 122, 808, 853
Cholesterol Management for Patients With Cardiovascular Conditions	AMI (Inpatient only)	121, 122, 808
	PTCA	112, 808, 852-854
	CABG (Inpatient only)	106, 107, 109, 546
	Stable angina	140
	Ischemia	832
Comprehensive Diabetes Care	Diabetes Diagnosis	294, 295
	Evidence of Diagnosis of or treatment for nephropathy	316, 317, 568
Follow-Up After Hospitalization for Mental Illness	Identify Mental Health Diagnosis	426, 430
Annual Monitoring for Patients on Persistent Medications	Identify Total Inpatient Discharges	1-2, 6-25, 34-46, 47, 48, 49-80, 82-90, 92-97, 99-189, 191-213, 216-230, 232-335, 336-345, 346-384, 392-395,396, 397-399, 401-404, 406-410, 413-423, 439-455, 461, 462 463-469, 471, 475-480, 482-483, 491, 493-494, 530-536, 538-587, 602, 604, 606, 607, 609-624, 626-631, 633-634, 635, 636, 641, 650-652, 700-716, 730-734, 737-740, 752-787, 789-829, 832-833, 836-839, 849-854, 864-867, 874-876
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Identify Inpatient Services	750-751
Prenatal and Postpartum Care Measures	Identify Live Births	370-375, 650-652
Births & ALOS: Newborns	Identify Total Newborns	602-624, 626-630, 635, 637-641
Chemical Dependency Utilization-Inpatient Discharges and ALOS	Identify Inpatient Services	749-751, 743-748
Discharges and ALOS: Maternity Care	C-Sections and Vaginal Deliveries	650-652, 370-375
Mental Health Utilization-Inpatient Discharges and ALOS	Identify Inpatient Services	424-432, 753
Frequency of Selected Procedures	Angioplasty (PTCA)	112, 808, 852-854
	Back Surgery	806, 807, 836, 837
	Cardiac catheterization	104, 124-125, 849, 850
	Coronary artery bypass graft (CABG)	106-107, 109, 546
	Lumpectomy	259, 260, 262
	Prostatectomy	306, 307
Identification of Alcohol and Other Drug Services	Identify Inpatient Services	743-751
Inpatient Utilization -Non Acute Care	Identify -Non Acute Care	462

Measure	Description	NYS AP-DRG
Inpatient Utilization: General Hospital/Acute Care	Total Inpatient-	1-2, 6-25, 34-46, 47, 48, 49-80, 82-90, 92-97, 99-189, 191-213, 216-230, 232-335, 336-345, 346-384, 392-395, 396, 397-399, 401-404, 406-410, 413-423, 439-455, 461,463-469, 471, 475-480, 482-483, 491, 493-494, 530-536, 538-587, 602, 604, 606, 607, 609-624, 626-631, 633-634, 635, 636, 641, 650-652, 700-716, 730-734, 737-740, 752-787, 789-829, 832-833, 836-839, 849-854, 864-867, 874-876
	Maternity	370-384, 650-652
	Surgery	1-2, 6-8, 36-42, 49-63, 75-77, 103-120, 146-171, 191-201, 209-213, 216-230, 232-234, 257-270, 285-293, 302-315, 334-345, 353-365, 392-394, 401-402, 406-408, 415, 439-443, 461, 468, 471, 476-480, 482-483, 491, 493-494, 530-531, 534, 536, 538-539, 545-550, 553-556, 558-559, 564-565, 567, 571, 573, 575, 579, 581, 583, 585, 606, 609, 610, 615, 616, 622-624, 641, 700-704, 730-732, 737-739, 755-759, 786-787, 789-793, 795-798, 803-809, 811, 817-819, 821, 823-824, 829, 833, 836-839, 849-854, 864-867, 874-875
	Medicine	9-25, 34-35, 43-46,47-48, 64-74, 78-80, 82-90, 92-97, 99-102, 121-145, 172-189, 202-208, 235-256, 271-284, 294-301, 316-333, 346-352, 366-369, 395, 396, 397-399, 403-404, 409-410, 413-414, 416-423, 444-455, 463-467, 469, 475, 532-533, 535, 540-544, 551-552, 557, 560-563, 566, 568-570, 572, 574, 576-578, 580, 582, 584, 586-587, 602, 604, 607,611-614, 617-621, 626-630, 631, 633-634, 636, 705-716, 733-734, 740, 752-754, 760-785, 794, 799-802, 810, 812-816, 820, 822, 825-828, 832, 876